Don't shoot the messenger when it comes to quality documentation and reporting

by Robert S. Gold, MD

I've said it many times: We're in the information, and business of medicine age. Using data to validate our performance and quality of care has led to many quality improvement initiatives. We used to receive feedback only during morbidity and mortality conferences. Now, there is a lot more information available to measures our care.

Amid all of these initiatives, people look for someone to blame for negative feedback. It's not the hospital or its personnel who are at fault. Our hospitals help us look good. Sure, they want to look good, too. But they also want to remain in business so that we have a place to practice and to see our patients.

These days, it's not only about the money. Don't get me wrong-money isn't a bad thing. Physicians realize that they can get a lot of money by limiting their efforts in assigning a minimum of significant codes, and ignoring the elements of documentation and coding that affect severity of illness and risk of mortality. But if hospitals don't look good, meaning the statistics show that they are not providing quality care or are apparently killing more people than they should because of the poor coding, next year's business will surely decline.

Let's start with the American College of Cardiology, the American College of Surgery, and the American Academy of Pediatrics. These organizations examine at the success that physicians have when treating certain diseases. They recommend that physicians follow practice guidelines to manage certain diseases, these guidelines measure our risk in dealing with these diseases. There are people in the hospital medical records departments who are aware of these initiatives, and are periodically asking questions to support our initiatives.

As for payment of outpatient services, Medicare and other payers look toward severity-adjusted capitation rates, meaning the more severely ill your outpatient population, the higher your adjustment for levels of patient interventions.

Would you rather spend a half hour on a level three outpatient visit for $17.50 or receive $36 for a level two visit? This is on the way, and those who do the calculating look at our current statistics to determine our future severity-adjusted payment rates.

Coders need all of the facts

The only way that physicians can tell whether we've achieved our goals is to provide all necessary information and respond to any queries. If a question isn't a good one, we can help coders understand what is important by educating them. Shooting the messenger is not the solution.

Consider these examples:

- Coders may ask us to help them identify patients who have chronic heart failure due to left ventricular systolic dysfunction so that we can help the national initiative to save the lives of these patients whose ejection fractions are under 40%.
- Coders may approach you regarding the specificity of Charcot Foot. If you don't provide documentation that the deformity was caused by autonomic nerve dysfunction because of the patient's diabetes, coders will report this as "due to secondary syphilis."
- Coders may ask whether patients having a total collapse of one lung because of tension pneumothorax, or cyanosis with severe hypoxemia, meet your criteria for acute hypoxemia respiratory failure.
- Patients with chronic background diseases are usually at a higher risk than patients who don't. Patients with acute conditions are often sicker than patients with chronic, stable conditions. If we don't document that these conditions exist, we hinder our ability to demonstrate that our patients are sicker than the others. We can help by answering these questions when posed, or by educating coders as to what makes a good question.

- If a coder asks whether you think a patient's anemia is caused by acute blood loss from the angiodysplasia that you cauterized, you might answer that the amount of blood loss was negligible in affecting the hemoglobin, and that the patient has had a B-12 deficiency because of atrophic gastritis, caused the anemia.
- If the coder asks whether a high creatinine level for an end-stage-renal-disease patient on dialysis represents acute renal failure, you might reply that the patient has no renal function, or can't have acute renal failure; the creatinine was elevated because the patient missed a dialysis session.

Patients are interested in our reputations; it's not good enough to simply take someone's word that a physician is capable. People are consumers who shop around for healthcare. Insurance companies and industries are consumers as well. They want to see low mortality numbers, low complication numbers, and reasonable costs.

When we don't provide enough information, we underserve ourselves and other members of the medical staff whom we count on to help us or to refer patients to us.

Statistics affect service lines

Hospitals have lost service lines because they couldn't advertise that they were better than a competing hospital. These hospital systems have lost preferred provider status from insurance companies because they couldn't statistically demonstrate that they provided excellent care.

Some physicians may wonder, "Who cares if I didn't say that the ruptured aortic patient had hemorrhagic shock? When I opened his belly, he was bleeding all over the place." The database cares.

The physicians at your hospital aren't only in it for the hospital. They're also there for the medical staff. As Vidal Sassoon said in 1985, "If you don't look good, we don't look good."

Editor's note: This article appeared in the January 2008 issue of Medical Records Briefing .

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JustCoding.com
Volume 52
January 16, 2008